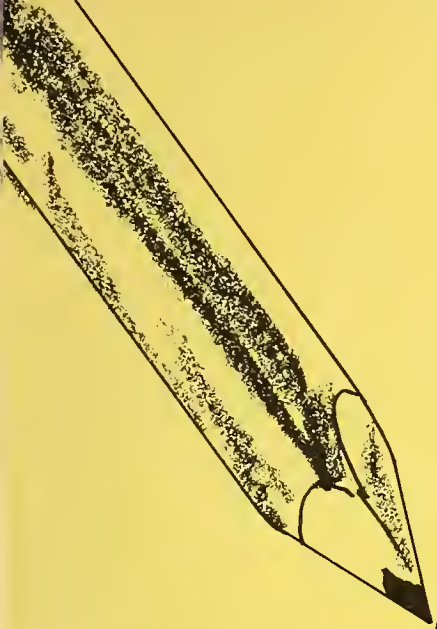

# Avoiding Erroneous Payments in State Medicaid Programs



Progress Through Partnership

Medicaid Medicare Management Institute

U.S. Department of Health Education, and Welfare
Health Care Financing Administration

# AVOIDING ERRONEOUS PAYMENTS

# IN STATE MEDICAID PROGRAMS

Medicaid/Medicare Management Institute
Health Care Financing Administration
Department of Health, Education and Welfare

November, 1979

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PREFACE

This special report represents part of HCFA's commitment to provide meaningful information and assistance to Medicaid and Medicare program managers. Through the Medicaid/Medicare Management Institute, we provide documentation of effective practices and procedures in various Medicaid and Medicare programs so as to encourage a national sharing of experiences -- a transfer of technology in health care programs.

These special reports will appear from time to time, as notable practices are found, or in order to convey the state of the art in managing various facets of a human services or health insurance program. We welcome your suggestions for future reports and your comments on the reports as they appear.

INTRODUCTION

The following series of reports is an amalgamation of knowledge and experience drawn from the Corrective Action Projects Division (CAPD).

CAPD is the unique division within the Medicaid/Medicare Management Institute which is designed expressly to provide on-site technical assistance to State Medicaid agencies in an effort to reduce Medicaid operational errors and their resulting overpayments. Three program areas, eligibility management, claims processing and third party liability (TPL), are the core of CAPD activities.

The division is composed of experienced program and systems analysts who work cooperatively with State staff on specific, well defined projects tailored to the needs and resources of the requesting State. CAPD is available to assist in all stages of a project, be it design, implementation or evaluation. CAPD may call upon other States with experience in the project area, other Federal offices and outside consultants for additional technical skill.

CAPD staff have already provided a variety of services to States. Projects focused on the design and development of comprehensive third party liability (TPL) systems (including both cost avoidance and post payment recovery) have been conducted in several States. Work in TPL has given CAPD staff increased awareness of the crucial role the intake office plays in TPL operations. The article "TPL Development in State and Local Agencies" examines the various components of the TPL intake process. Forms simplification and reduction, error prone profiling, and caseworker training have been carried out by CAPD as a means of improving the Medicaid eligibility determination process. It is from experience in the latter two activities that the articles on "Approaches to Increasing Caseworker Efficiency" and "Error Prone Profiling" evolved. CAPD's function as a consultant in the use of MMIS management reports has lead to the article on "Innovative Uses of S/UR."

Martha Green, Thelma Johnson, and Linda Stella, authors of three of the articles, were staff members of the State Management Branch in CAPD at the time the compositions were completed. Beth Holmstrup was employed by CAPD's predecessor, Corrective Action Project. Systems Architects, Incorporated, responsible for "Error Prone Profiling" is a contractor utilized by CAPD.

Through its experiences with States, CAPD has gained invaluable knowledge and insight into the needs, problems and exemplary practices in Medicaid program operations. These articles are presented to State Medicaid officials and all other interested parties as a way of sharing expertise.

For additional information on the above topics or related areas, contact Mr. Arthur A. Pergam, Director of the Corrective Action Projects Division at (301) 594-8942.

# INNOVATIVE USES OF S/UR

by LINDA M. STELLA

## Introduction

The Surveillance and Utilization Review subsystem (S/UR) of the Medicaid Management Information System (MMIS) is a post-payment review system designed primarily for the detection of potential fraud and abuse in the Medicaid program.

The purpose of this article is to demonstrate additional ways in which S/UR generated data may be utilized to save Medicaid program dollars. To limit the subsystem to fraud and abuse detection would be to ignore the potential of this versatile system. Program wide utilization data, summarized by category of service, provider type or recipient groupings are available. Items such as "Total Dollars Paid," "Number of Office Visits" and "Number of Drug Rx's" can be used in additional manipulations. The S/UR Subsystem automatically generates averages, standard deviations and frequency distributions for selected items which can be used for a variety of studies.

Information on S/UR management and individual level reports, summarizing data elements from provider submitted invoices, can be analyzed for cost containment proposals, policy recommendations, improved delivery and receipt of health care, and participant education.

Rather than discarding or storing the S/UR output after exceptional providers and recipients have been identified, several States have made innovative uses of S/UR data. The experience of one such State, Minnesota, has some unique features and will be highlighted here.

## Provider Enlightenment

A key word for any S/UR organization is visibility. The S/UR reports can be used for presentations to professional associations and societies. Through these presentations, the provider community is made aware of the method in which their activities are being monitored by the State agency. Showing health professionals actual data from an S/UR run can be revealing. They are impressed with the volume of summarized data that can be displayed for a peer group. Most providers do not realize S/UR potential to analyze treatment patterns from exception profile and treatment analysis reports. These reports are frequently shocking to provider groups when they show that a member of their profession emerges so far from the norms. Responses to such data range from "How can we help you to get this person removed from the program before he appears in the headlines to embarrass our profession?" to "I know who that person is even with the name removed." Even more shocking to professional organizations is the realization that all of this information comes from the Medicaid invoices they submit. Frequently, additional speaking invitations will follow the initial presentation by S/UR staff as word spreads of the type of information produced by the State Medicaid program. This increases S/UR's effectiveness as a deterrent to misutilization.

Recipient Control

Minnesota utilizes its S/UR data to identify recipients for a restriction (also called a lock-in) program. The restriction program limits the number of providers from whom a recipient can obtain services. Recipients who have misutilized the medical program, especially in the drug, physician, dental and optometric areas, are targets for restriction. When potential abusers are identified, a case history is prepared for review by a committee of health professionals. If the committee recommends restriction, the S/UR recipient unit contacts the appropriate county welfare agency. The recipient is called into the county office for an interview. At that time, the recipient is allowed to pick the specific pharmacy or physician or both they wish to utilize. A restricted medical eligibility card is then issued. The providers to whom the recipient is restricted are listed on the reverse side of the card. (The recipient can receive emergency care from any provider.) The restricted recipient can also receive routine medical care and services from other non-restricted provider types and there is also a system for referrals to specialists. However, if services are received from a pharmacy or physician other than those to whom the recipient is restricted, that provider's invoices will be rejected. It is therefore to a provider's advantage to check medical ID cards at every visit.

The restriction program has been in effect since 1976, and has proved beneficial. Besides cutting program costs, quality of care has been improved by eliminating or preventing cross-therapies and harmful drug interactions. For instance, one Medicaid recipient went to more than 60 pharmacies receiving drugs prescribed by more than 30 physicians and dentists. The restriction program limited this recipient to one physician, dentist and pharmacy for routine care. Additionally, as a result of committee recommendation and legal efforts, the recipient was placed in a drug rehabilitation program. This recipient's quality of care was truly improved, while expenditures for drugs and visits decreased. Recipient education, conducted by the county agency at the time of the restriction interview, is also a beneficial by-product of the program.

Child Abuse

Currently in Minnesota, any invoice with a diagnosis of child abuse is forwarded to the S/UR recipient unit. The unit, in turn, contacts the recipient's county welfare agency to verify that this incident has been properly reported. Additionally, items combining diagnoses and procedures which may be indicative of child abuse can be put into the children's class groups on the S/UR reports. Any exception profile reports generated as a result of these items can be analyzed to see if, in fact, child abuse is indicated. If it is, the case can be reported to the county welfare agency for appropriate action.

Drug Utilization Review Project

The Drug Utilization Review (DUR) project in Minnesota was initia-

ted in late 1978. The project goal is to make pharmacists and physicians more keenly aware of drug usage and potential drug interactions in their clients, thus improving quality of care. Unlike the restriction program, DUR attempts to identify and correct inappropriate utilization of drugs based on therapeutic criteria. If recipients could be encouraged to properly follow their drug regimens, Minnesota anticipated that additional health care costs, such as physician visits and outpatient hospital charges, could be avoided. Also, when analysis of a recipient's case revealed that the recipient was going to several physicians and getting contraindicated drugs, the recipient was encouraged either to seek care from only one doctor or to tell all doctors involved of the treatment received from the other providers.

To aid in the project, Minnesota produced several types of reports from S/UR data, to relate drug therapies to diagnoses, and to monitor overall prescribing, dispensing and usage patterns. Reports by recipient and by specific therapeutic classes are routinely produced for physicians and pharmacists participating in the project. These providers review their own clients and practices in relation to drug-diagnosis and multiple drug interactions. Physicians analyze which drugs they prescribe most frequently and in relation to which specific treatments. Routine or automatic prescribing habits become readily apparent and can be corrected. Pharmacists are sensitized to dispensing patterns and are encouraged to contact physicians when potential drug interactions could occur. Regional coordinators perform follow-up analysis and peer review to determine if practice or dispensing patterns have been affected as a result of participation in the project.

Fraud and Abuse Initiatives

The Minneapolis-St. Paul area was chosen as a target sight for Project Crackdown. Project Crackdown was an attempt to identify "croakers" in the Medicaid drug program. "Croakers" are those physicians and pharmacists who supply drugs, with a potential for street re-sale, to known abusers. The flexibility of Minnesota's S/UR subsystem allowed the S/UR staff to add specific items relating to known, abusable drugs, into physician, pharmacy and recipient S/UR reports for one run. The exception profile reports which came out were analyzed to find the worst examples of drug misutilization. Actions culminating in program restrictions are in process for those few identified offenders.

Other ongoing fraud control efforts by the Minnesota S/UR Division are greatly enhanced by the presence of good computer output. The availability of usable provider exception and treatment analysis reports may be the deciding factor in determining whether or not a county attorney or attorney general will pursue a case. When outside complaints from county attorneys or the attorney general become substantial enough to warrant further inquiries, the presence of a significant number of exceptional items on an individual exception summary report or an unusual diagnosis-treatment pattern on a treatment analysis report may make the difference in case presentation. Prosecutors have been impressed by the presence of good data which can be used to give direction to a difficult investigation.

Research Projects

The abundance of data available through the S/UR system also makes it a viable vehicle for a variety of research projects which may eventually lead to policy modifications.

Minnesota is one participant in a post-marketing drug survey being conducted for the Food and Drug Administration (FDA). Under FDA rules, pharmacists and physicians are supposed to report any observed contraindications resulting from patient use of newly marketed drugs. This reporting very seldom occurs. It was determined that the Medicaid population would be one accessible sector where the required data could be tracked. Therefore, Minnesota's 200,000+ eligible recipients are being used as participants in this project. A basic assumption of the project was that Medicaid recipients would be receiving some of these newly marketed drugs through their routine therapies. No special dispensing of drugs would be required. For each cycle in the project, the initial phase is to identify those Medicaid recipients who have received the targeted, newly marketed drugs. The medical history of these recipients is then tracked for several months to determine if the drugs' use has effected any changes in the recipients' health care. Any adverse changes are especially noted. The data required by the FDA is then forwarded to the agency's contractor on tape, to be merged with data from the other States participating in the project. The data will be correlated and analyzed, and the findings on the newly marketed drugs will be closely monitored to see if the drugs can remain on the market.

Two individuals are using S/UR data for their doctoral theses. The data are being used for all the Medicaid recipients in their respective samples. Strict confidentiality procedures were negotiated and enforced during these projects. One study is ascertaining the effect that consulting pharmacists have on drug costs in skilled nursing facilities and intermediate care facilities. Additionally, an evaluation is being made of the cost differentials when the consulting pharmacist is also the supplier of the drugs. The Department of Public Welfare (DPW), pharmacy organizations and others are eagerly awaiting the reports coming from this study. The other thesis is an evaluation of the costs of medical care for older citizens. Comparisons of health care costs for those living at home and those in long term care facilities are being conducted. Individual health assessments were made on each participant. The medical histories for each person, from the assessment date forward, are then being analyzed. Other MMIS data are being used to track recipients' resources during the time period. This study will also result in a special report to DPW on suggestions for improving gerontologic care.

Two other projects using S/UR data are currently being carried out by the single State agency. The first of these is a Medicaid utilization study comparing utilization of various health care services by Medicaid recipients with that of patients participating in other third party programs in the State. This study is designed to identify differences in the utilization of health care services between pro-

grams. The results of the study will then become a basis for further planning for cost containment. A second very small study is being done to see if S/UR data can be utilized to identify Medicare eligible patients under 65, based on various selected diagnosis codes.

PSRO Monitoring

The treatment analysis reports from the S/UR subsystem are being used in Minnesota as part of the plan to monitor the PSROs. The top 20 discharge diagnoses, based on volume, were obtained from the PSRO. A diagnosis class group was then created for each diagnostic category. Data relating to hospital discharges (e.g., lengths of stay, specific ancillary charge data, admit/discharge days, accomodation data, etc.) were prepared for each diagnostic group and entered into the S/UR control file. Specific length of stay data are then collected for all discharges -- total, surgical and non-surgical -- by PAS age breakdowns. A PAS study done for the Minnesota PSRO region was used to obtain diagnosis specific lengths of stay. Hospitals with lengths of stay in excess of those entered for the various discharge categories will come out as exceptional. A provider detail, specifying the diagnosis and time period involved, will be ordered for each exceptional hospital. All claims on the provider detail will be analyzed, and those with exceptional lengths of stay will be subjected to further review according to the monitoring plan.

As the top 20 discharge diagnoses change over time, the S/UR control file can be amended to reflect current needs.

Continuing Education

The departments of Continuing Medical Education and Continuing Education in Pharmacy from the University of Minnesota, with cooperation from the Minnesota Surveillance and Utilization Review Division, have used S/UR data for continuing education courses for credit for physicians and pharmacists. The first such conference focused on drug therapy for older adults. Information from the S/UR Subsystem was used in a program on drug use patterns in Minnesota. Recipient exception profile reports and detailed case histories were used in other presentations on how to do profile analysis and problem identification. The case histories were then used in small group sessions to put these skills into practice.

Another continuing education conference is being planned on "Conception Control." Once again, S/UR recipient case histories will be used as teaching tools. It is anticipated that S/UR materials will be utilized for additional conferences for many health care professionals in Minnesota. As was previously mentioned, this exposure by health professionals to S/UR data is not only educational but has a profound deterrent effect to fraud and abuse in the program.

Conclusion

Based on the variety of projects undertaken in Minnesota, the uses

of S/UR data are limited only by the user's imagination and the system's flexibility. S/UR is an expensive system. However, maximizing S/UR through the use of the data for a variety of projects, including fraud and abuse detection, can eventually make its benefits outweigh its costs.

ERROR-PRONE PROFILING

by SYSTEMS ARCHITECTS, INC.

In the 1960's, the Dallas Cowboys installed a computer-based analysis procedure that allowed them to better select college football players in the annual draft. Their method consisted of a statistical profiling technique that had been used successfully in a range of other applications. The approach statistically analyzed player characteristics and performance over time to determine which characteristics were most indicative of success in professional football. The player traits examined were subsequently used to define an estimate of future performance for each potential drafted player. The method proved so successful that similar systems are now in use by all members of the National Football League, and when the Seattle Seahawks were organized they hired several senior members of the Dallas computer systems staff to set up their own player selection system.

The District of Columbia, from May, 1977 to April, 1978, applied a similar statistical profiling technique in their AFDC program. During this time period, they established a special team to review some 20% of the AFDC caseload, which had been identified by a statistical method as the cases most likely to be in error. Using the statistical method, the special team found almost twice as many cases to be in error than if they had selected the cases at random. The U.S. General Accounting Office estimated that $3.5 million in erroneous payments were saved because of the effort.

These two examples illustrate the results that can be realized when statistical profiling techniques are used to categorize individual members of a group for later special attention. In the various public assistance programs, as in the District of Columbia AFDC program, the use of statistical techniques to identify likely case errors and make corrective action on those errors has often been referred to as "Error Prone Profiling" or "EPP."

The statistical profiling concept was first developed in the 1930's and later formalized in application to large scale problems during World War II. Supported by new generations of high-speed computers, the technique was first applied to social science problems in the 1960's. The method has shown great versatility and has been applied in many ways to a variety of situations since its development. EPP has been employed with success in a number of State public assistance programs.

EPP As An Error Profiling Tool

Why should a State use EPP? In a public assistance program, a large share of dollar loss arises from a small percentage of the total number of transactions occurring in the program. Experience and analysis in the Medicaid program have demonstrated that approximately 15% of the recipient cases invariably contain a major portion, 80% or more, of the total error conditions in the caseload.

Staff resources adequate to review and correct an entire caseload are never available. If that high error 15% of cases could somehow be cheaply and accurately identified, even existing staff could easily realize an 80% reduction in error by thorough review of just those cases. This is exactly what Error Prone Profiling tries to accomplish, through a statistical analysis of quality control data.

Obviously, no statistical system can identify precisely which cases will be found to be in error. But statistical analysis can identify groups of cases which are much more likely to be in error than the average case picked at random, and thus can greatly increase the payoff for special corrective action activities focused on those cases. For example, the EPP system in New Hampshire selected only 20% of the caseload, but these cases turned out to contain 42% of the total errors in the caseload. On the cases selected, 54% were found to be in error.

EPP as a Management Tool

How does EPP work in a public assistance program? EPP relies on a statistical approach to generate an estimate of an individual case's error-proneness. This estimate is derived from a quantitative analysis, based on the case's particular characteristics, of quality control data to determine how specific case traits correlate to error conditions in the caseload. In particular, the analysis determines whether a given case trait (e.g., earned income) is indicative of error or not. This analysis is used to form an error profile that is matched against the caseload to determine a likelihood of error for each case.

The use of an error profile allows the program manager to develop a corrective action strategy for the caseload based on the generated estimates of each case's error-proneness. An error profile leads to greater efficiencies in program administration, first, through a greater ability to detect error and, second, through the capability it gives management in planning corrective action.

EPP analysis permits the manager to maintain an overview of the total caseload and identify priorities. Resources can thereby be allocated according to the needs of the total caseload. Computer based systems can do the otherwise tedious work of partitioning the caseload and identifying the most error-prone cases. Managers are then freed to concentrate their efforts where the need for resources exists, and where corrective action will have the maximum impact.

These advantages, however, should not cause EPP to be viewed merely as a system to detect recipient misrepresentation, since in many States the proportion of errors is weighted more in the agency's disfavor than in the client's. In South Carolina, for example, in a review of their AFDC caseload, 67% of the case errors were determined to be agency errors. EPP also should not be considered only as a quick method to reduce a few specific areas of error, for it has the ability to be applied as a dynamic management system to plan the entire work-

load of the agency error correction effort.

EPP Implementation Methodology

Implementation of an EPP system consists of four main subsystems. These are: 1) a data collection subsystem; 2) a profile generation subsystem; 3) a case action subsystem; and 4) a performance evaluation subsystem. These four phases make up a complete cycle of EPP implementation and on-going operational activity in a public assistance program.

The data collection subsystem ensures that the data necessary for corrective planning is collected and stored in an automated data base. Data on these characteristics are obtained primarily from quality control data which consists of a random sample of cases selected for review. Supplementary characteristic data may also be collected if the quality control data is insufficient for computing the profiles.

The profile generation phase is comprised of the computer programs that calculate the profiles. There are a number of different statistical techniques that can be used to compute profiles, each being preferred for different intended uses. Three basic approaches are presently employed by States using the profiles. These are: 1) scoring the cases; 2) classifying the cases; and 3) identifying the highest error-prone group among the cases. The method used determines the strategy of corrective action taken on the caseload.

The case action selection system involves the different types of action that can be taken on cases and the strategies employed in these actions to eliminate agency and recipient errors. The actions taken are based on the information that a case is error-prone or non-error-prone. In a scoring approach, the caseload is reviewed in accordance with each case's assigned score that indicates the probability of error. When the caseload is classified, the entire caseload is broken into groups each having a high probability of a specific type of error and each of which is given its own specific corrective action. In the method of identifying the highest error-prone group, a specialized review team is assigned to review the cases identified as most error-prone.

The performance evaluation system is intended to make the other subsystems perform more effectively. This subsystem provides estimates of error rates and erroneous payments to measure the impact the EPP system is making on the overall program. It evaluates the benefits achieved versus the costs incurred.

These four subsystems should be seen as working together to form a complete EPP management system.

EPP Use in State Public Assistance Programs

A number of States have installed a form of EPP or similar system in AFDC and have plans to expand the systems to Medicaid. New Hamp-

shire has developed and has in operation a well-defined EPP system for Medicaid, as do West Virginia and South Carolina for AFDC. These States presently employ the different approaches to error-prone estimation mentioned above for defining the workload of corrective action in their State programs.

South Carolina scores every case according to error-proneness and reviews cases in order of priority from highest to lowest. A score is calculated by the computer for each case in the caseload. The score is an indicator of the probablility of error, and is used to rank the cases in order of priority for processing. The score tells which cases should be reviewed first, specifying careful review for the error-prone cases and only a cursory review for cases scored with a low probability of error.

West Virginia classifies the caseload into several homogeneous groups and specifies the case actions to be taken for each group. Case traits that have been shown in the error analysis to be indicative of a specific type of error (e.g., overpayment, underpayment) are used to divide the caseload into several groups, each of which is given a specific corrective action.

New Hampshire seeks to identify the single most error-prone group meeting a minimum error rate or minimum percent of the caseload. A matrix of case characteristics that correlate to given error rates in the caseload are determined by statistical evaluation of case traits. The computer then splits the caseload into two groups, an error-prone group with a specified minimum error rate or representative of some specified minimum percent of the caseload, and a non-error-prone group. The error-prone group is then subjected to an intensive review by a highly trained team.

The results of these EPP system implementations have been remarkable. In all three State programs mentioned above, EPP has increased the error detection rate and made a positive impact on administrative costs.

In South Carolina, the case error rate was reduced from 18.0% to 15.0%, between July - December, 1977, and April - September, 1978, a 17% decline. The total proportion of dollars paid out in error dropped from 7.8% to 7.1%, a 9% decline. In monetary terms, the system resulted in a savings of $210,000 per month.

The system in West Virginia has been in operation for some six years and has achieved impressive results. The case error rate declined from 20% to 12% in three years from 1973 through 1976. The payment error rate declined comparably, from 7% to 4%. An increase in error rates to 5% after 1976 has been attributed to a 50% increase in workload per caseworker. The increased workload has not been matched by a similar rise in adminstrative costs.

The Medicaid EPP system in New Hampshire has also proven an effective system. It has been shown to have a 7:1 benefit-to-cost

ratio in several local offices on a test basis as evaluated by an independent contractor. If the system were to be implemented Statewide, likely savings were estimated at $1,351,000 in the first start-up year and $2,027,000 in the second year of operations.

Benefits of an EPP System

EPP systems as they have been employed in a few State public assistance programs have proven effective in reducing program and administrative costs. Although choosing options from a wide range of appropriate EPP implementation procedures may involve some careful thought, this should not dissuade the potential program manager from considering the advantages of an EPP system. Indeed, the variety of models tested to date means that the manager can readily find at least one proven system which is readily adaptable to his program's operating characteristics and environment.

Whatever model is chosen, EPP analysis structures the priorities of action and brings relevant information into the corrective action decision. The classification of the caseload into groups of varying error potential determines the direction and priority of staff effort. This focusing of effort can realize great savings in operating costs and reduce the amounts of mispayments to ineligible recipients.

EPP is a most powerful method of analysis. To the manager, harassed by inadequate staff, out-of-control workload, and legislative, executive and public demands for reduced costs, it can be a key to greater efficiency.

# APPROACHES TO INCREASING CASEWORKER EFFECTIVENESS IN STATE MEDICAID AGENCIES

by BETH HOLMSTRUP and THELMA JOHNSON

## Introduction

The Medicaid program covers medical services for approximately 24 million low-income individuals at a cost of $16 billion annually. Of that amount, an estimated $2 billion in Federal and State funds are misspent each year. The Health Care Financing Administration is working with all States in an effort to reduce erroneous expenditures. HCFA's Medicaid Quality Control (MQC) program has been expanded to detect and estimate the cost of errors in claims processing and third party benefit recovery as well as eligibility determinations. In addition, the Medicaid/Medicare Management Institute's Corrective Action Project (CAP), created in 1978, offers on-site technical assistance to State Medicaid administrators. CAP staff work closely with State staff to identify management problems which lead to MQC errors and to design and implement management improvement projects tailored to the needs and resources of each State. Key to reducing erroneous payments is the caseworker.

Medicaid eligibility caseworkers perform a vital and sensitive role in adminstering the Medicaid program. It is the caseworker who explains the Medicaid program to claimants, who advises claimants of their responsibilities and who obtains the information used to determine an individual's eligibility for the program. Therefore, good management demands environments that enhance caseworker effectiveness. The various approaches described here are designed to provide assistance for State and local administrators to increase the effectiveness of Medicaid eligibility caseworkers and for the most part are drawn from State experiences.

Training programs, personnel practices, performance standards, work management, working conditions, and sensitivity sessions for "burned-out" employees are described; names and phone numbers of contact persons are also included to facilitate the exchange of information.

## Administration and Management

Novel Training Programs: From data available on training, it appears that in many States, as little as five percent of all funds devoted to training AFDC, Title XX and Medicaid agency staff may be spent exclusively for training in Medicaid eligibility determination and case management. Program managers should appraise the adequacy of training for Medicaid staff, as there is a relationship between the adequacy of staff training programs and error reduction. The University of Alabama's Developmental and Exploratory Study of Effects and Effectiveness of Employee Training by State and Local Welfare Agencies documents that those districts with the most training enjoyed the

lowest error rates. Specifically, the lowest error rate districts in the Food Stamp, AFDC, and Medicaid programs offered more policy and procedures training on client eligibility determination and budget computation than did the highest error rate districts.

When developing a training improvement plan, a manager/supervisor should assume that the plan outlines measureable training objectives and identifies specific implementation tasks and responsibilities. Program implementation should be closely monitored against a written work plan or timetable, and the program's effectiveness should be evaluated in terms of training objectives.

Several State and local agencies have developed unique and effective training programs. Following is a description of some of those programs.

1. The SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES has developed a four-month extended training program for new eligibility workers. Although the program focuses on developing workers who are specialists in AFDC, the concept and the methods are applicable to the workers responsible for Medicaid cases. The key elements of this program, in addition to its length, are the induction training followed by up to three months of on-the-job training with a reduced caseload, and close supervision by experienced trainers. Trainees are periodically evaluated with specially designed performance standards for early identification of workers who may need further training or continued close supervision. This program has played a part in the reduction of the AFDC error rate in San Francisco from 20% in 1975 to 3% in 1978.

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2. The STATE OF WISCONSIN has designed a training package for AFDC workers which they believe can serve as a model for many State welfare agencies. The Wisconsin Interactive Teaching System (WITS) is an individual problem-solving training model for both individuals and groups in theoretical and applied AFDC policy. The WITS includes diagnostic case studies to aid the trainee in identifying policy areas needing clarification, and programmed instruction which teaches AFDC policy. The WITS provides the most beneficial learning experience when combined with on-the-job experience. Subsequent to training staff, the WITS may be maintained as an agency resource to be used primarily by supervisory staff. The teaching component of the program is easily transferable from one State to another because the decision-making process described is universal despite inter-State program variations. The WITS addressed the common defects of many training programs by offering individualized, timely, and continuous learning with sound reference materials.

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3. LOS ANGELES COUNTY utilizes a Medi-Cal Assessment Test prior to staff development sessions to identify training needs. The test consists of 105 multiple choice and true/false questions on detailed policies and procedures. Any staff member who does not receive a minimum score of 80% on the test must participate in training. Los Angeles County has discovered that this knowledge test proves an effective tool for assessment of training needs.

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4. NEW YORK CITY PUBLIC WELFARE staff development personnel participate in task analysis workshop. In this approach, the usual method of describing and designing jobs has been expanded to the concept of work design which focuses on the participant's job, work environment, tasks and skills. Task analysis is utilized in the areas of problem solving, defining jobs, identifying training content, improvements in communication, standard setting and staff development. The nine-day workshop seeks to enhance knowledge and skills in task analysis, job design and staff development as well as to define common staff objectives and relationships.

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5. The MEDICAID/MEDICARE MANAGEMENT INSTITUTE in Baltimore, Maryland houses a clearinghouse of training materials used by the States. This publications repository can serve as a referral resource for States interested in expanding or redesigning their programs. These materials are indexed by State and should be so identified when contacting MMMI. A list of some of these training materials can be found in the Appendix.

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Performance Standards: Federal regulations on Personnel Administration address the issue of employee performance in Merit Principle IV. It reads: "Employees will be retained on the basis of the adequacy of their perfomance and provision will be made for correcting inadequate performance and separating employees whose performance cannot be corrected." The use of performance standards aids the supervisor and agency in evaluating a worker's performance by outlining production units which can be reasonably expected of an employee. Employees in turn know what is expected of them. The standards are developed through work measurement to quantify the time required for a qualified worker to accurately complete the tasks assigned. Following are two approaches developed.

1. LOS ANGELES COUNTY has developed a work measurement program, "Group Performance and Control," which also addresses staffing requirements and administrative cost control. The system began with a set of time standards developed with a basic measurement technique. Factors, or time values for several standards,

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are then derived. Reference reporting is conducted for two to ten weeks with the end result being a time value for each task, a time value for productive interruption, an allowance for unmeasured work, a training allowance and the average amount of lost time. These time values and the amount of time available are integrated to create a yardstick of production units for eligibility workers and clerical staff. These yardsticks then become a management tool to facilitate proper staffing for the most efficient delivery of services.

In the Los Angeles experience, total commitment of the administration was found to be absolutely essential to permit implementation of a work measurement program. After initial opposition by both workers and administration to this concept, yardsticks are an integral part of the personnel practices and the unions of the county.

2. A similar success story occurred in the SOCIAL SERVICES AGENCY OF ALAMEDA COUNTY (CALIFORNIA). A Medi-Cal District Workload Measurement Project was undertaken which resulted in finding a caseload standard for the agency to be 274.5 cases per worker. The old standard for Medi-Cal eligibility workers was 150. On April 4, 1978, all Medi-Cal workers were assigned an additional 100 cases, for a new total of 250 continuing cases - a 65% increase. This was accomplished with the aid of the employees' union which did not dispute the quantified data of the work measurement program.

   Contact
   Librado Perez
   (415) 874-5008

   Alameda County also has a Management and Organizational Development Program. Each employee develops an annual personal development plan prepared jointly by worker and supervisor. These measures have contributed to real communication between management and line staff, and a highly positive attitude on the part of all employees towards the agency's mandates and mission.

Personnel Practices: A great many investigations have been conducted over the years to determine what employees want from their jobs. Although the results of these surveys differ in detail, they agree in major dimensions.

As basic requisites, people expect good pay, safe and healthful conditions of work, and steady employment. These elements are well understood by manager and worker alike. But beyond these essentials, employees want other things: interesting work; opportunities for advancement and growth; cooperation and help to get the job done right; treatment with respect and dignity; opportunities to influence decisions affecting them; and reasonable social interaction on the job.

There are no easy solutions to the problem of employee alienation. However, considerable experimentation, effort, time and resources have been used to affect real changes. Following are two approaches.

1. A NATIONAL STUDY OF SOCIAL WELFARE AND REHABILITATION WORKERS, WORK AND ORGANIZATIONAL CONTEXTS conducted by the Human Resources Research Organization (HumRRO) identifies a model for agency priorities which yield the most beneficial effects on employee satisfaction and performance, absenteeism, turnover, agency competence and performance. The recommended priority ranking for attention by agency administrators and managers (in descending order) is: agency goals; agency policies; communication; supervision; structuring of activities; stability of work environment; size of agency; and geographical dispersion of the agency.

Contact
Barbara Vermillion
(703) 549-3611

HumRRO also addressed the issue of personnel management in the work context. This study delineated three sets of factors enhancing employee proficiency: loyalty, identification and motivation. The function of personnel management is viewed as the integration of all factors at an optimum level with a formal monitoring system.

2. (EMPLOYEE INCENTIVES TO IMPROVE STATE AND LOCAL GOVERNMENT PRODUCTIVITY - NATIONAL COMMISSION ON PRODUCTIVITY AND WORK QUALITY). One factor enhancing employee motivation is a formal system for incentives, reward and recognition of outstanding employee performance. Various types of employee incentives now being used by the State and local governments are: leave and attendance incentives; career development and educational opportunities; competition and contests; job enlargement with job rotation or redesign; performance targets and output; oriented merit increases or bonuses; safety incentives; shared savings; suggestion award programs; and variations in working hours.

Work Management: Caseload and work management is an essential responsibility of workers and agencies striving for optimum use of staff for the most efficient delivery of services. The Office of Family Assistance (DHEW) in its Guide To Workload Management for the Worker in Income Maintenance defines workload management at "a continuous process that encompasses needs assessment, development of objectives and of a work plan organizing the work according to recipient and agency needs, and of controls to provide essential feedback and evaluation."

Contact
Bob Laue
(202) 245-8913

Work management provides benefits for all components of a public assistance agency. The caseworker's efficiency and effectiveness are improved and job satisfaction increased. The agency may create a more efficient service delivery system and reduce errors. The likelihood of the client receiving proper assistance in a timely manner is increased.

Following are some approaches to work management.

1. Because of the broad effect of work management on all facets of the income maintenance system, management approaches which enhance caseworker effectiveness are varied in focus and comprehensiveness. For example, COOK COUNTY, ILLINOIS, was faced with the pressing need for a method of complying with the Federal requirement for a 45-day processing limit for AFDC applications. A system titled "forward flow" was designed to reduce the backlog of unprocessed assistance applications. Basically, forward flow segments the duties of the caseworker into three separate functions and jobs. An application worker establishes initial client contact, distributes forms and sets up interview appointments. An eligibility worker processes the applications and supporting documents. Home visits, where required, are made by the verification worker. However, forward flow has several drawbacks. There is not one worker with whom the client can identify during the intake process. Caseworker accountability may be weakened as this "assembly line" approach reduces client rapport and a sense of completion. Nevertheless forward flow may be useful to States confronting intake management problems in high caseload areas.

Contact
Bob Jansky
(312) 793-3378

2. SAN DIEGO (CALIFORNIA) COUNTY has experimented with a new screening and scheduling system in the AFDC intake process with the objective of optimizing staff resources and minimizing client inconvenience. Under this new system, applicants are screened by a specially trained pre-application worker prior to an intake interview. This screening identifies most ineligible clients through the use of a one-page rather than the normal nine-page application form. Those applicants who pass the screening are given a check-list with a list of necessary documents and an appointment for an intake interview within five days. This system has reduced client waiting area time and the time required from application to the receipt of assistance. The benefit of pre-application and screening from the management perspective has been the control of intake workload through improved scheduling and the focusing of staff resources on those most likely to be eligible. One inconvenience to the client is that the applicant would be required to return to the office for a 2nd interview.

Contact
Bill Wiehl
(714) 236-4053

3. An essential aspect for the achievement of workload management is the degree of agency support given workers who must deal with their caseload on a daily basis. Agency support may take many forms and directions: the use of an error prone profiling system, for instance, can assist workers in managing their caseloads by identifying cases worthy of further verification or documentation, or by identifying more productive redetermination scheduling. Automated systems can also produce an often immeasurable

Contact
Kathleen Johnston
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effect on caseload management. For example, MARION COUNTY (INDIANA) DEPARTMENT OF WELFARE'S case financial summary has reduced the amount of manual input and time a worker must devote to processing a case. The morale of workers has increased as they perceive benefits accruing from increased client contact. In addition, clients with emergency situations may be handled swiftly due to the worker's ready access to file data.

4. WISCONSIN has developed and implemented an automated eligibility system for its income maintenance programs. An intake worker assists clients in completing a single purpose application form for AFDC, Food Stamps and Medicaid benefits. A data entry clerk inputs the client data to the system directly from the application form in about four minutes. Within a few seconds, the automated system determines eligibility, computes the cash grant, spend-down or share of cost amount and the Food Stamps payments, and prints out a hard copy case summary. An integral element of the manual phase of this automated system is the policy handbook which is designed as the English version of the computer's programming. This "decision logic" format reduces most eligibility determination decisions to "yes/no" questions and answers, minimizes errors due to caseworker judgment or poor training, and may be utilized for the policy manuals of States without an automated eligibility system. Both aspects of this system enhance caseworker effectiveness by increasing accuracy and decreasing case management demands.

Contact
Bernard Stumbras
(608) 266-3035

5. Another technique of case management is monthly client reporting systems, where beneficiaries are required to report income and resources on a monthly basis or face a loss of benefits. DENVER AND BOULDER (COLORADO) COUNTIES are currently engaged in a monthly reporting pilot project for the AFDC caseload. Preliminary evaluation indicates a significant benefit/cost savings as a result of monthly reporting requirements.

6. Several counties in CALIFORNIA have implemented monthly Medi-Cal Status Reports. The State of California has documented that counties can expect a 10 to 15 percent one-time drop in their caseload with the implementation of status reporting. In addition, both monthly and quarterly reporting significantly reduce the growth rate of Medi-Cal caseloads.

Contact
Barbara Carr
(916) 445-1797

7. NEW YORK has expanded the concept of caseload or work management to encompass job process management. The process concept of work flow, defined in terms of tasks, has been broadened in training to include

Contact
Arnold Harris
(518) 472-7895

worker and supervisor's interviewing skills, value systems, reactions to clients and other human service skills. The focus of the training is upon relating necessary tasks and functions to the efficient management of time and workload. The staff reaction to this program has been extremely favorable. The School of Social Welfare at the University of New York at Albany has developed excellent training materials for workers and supervisors which include this focus on job process management.

The Office of Family Assistance (located in the Social Security Administration of the Dept. of Health, Education and Welfare) has printed several publications which deal with work management. They are:

1. Task Analysis and Job Design for Public Assistance Agencies. As Illustrated by Eligibility Determination. SRS 73-21204. Jan. 1973.

   This publication was developed to illustrate the procedures involved in applying functional job analysis to manpower planning in the assistance payments processes of public assistance agencies.

2. State Monitoring of Local Office Performance. A How-To-Do-It illustration describing the State monitoring systems in the States of Washington and Maine. SRS 77-21221. June 1975.

   This publication describes the monitoring systems in Washington and Maine to determine whether the agencies' policies, standards and methods promote effective accomplishment of the agencies' objectives.

3. Work Measurement and Workload Standards as Management Tools for Public Welfare. Michigan. 77-21224.

   July 1974. This publication presents the details of an empirical investigation into requirements for manpower. The study was conducted by the Michigan Dept. of Social Services for the purpose of developing staffing standards based upon workload rather than caseload volume. Copies of these three publications may be obtained by writing to:

   Office of Family Assistance
   Social Security Administration
   330 C Street, S.W.
   Washington, DC 20201
   Telephone Number: (202) 245-2771

Sensitivity Enhancement: Caseworker burn-out is an occupational hazard of public agency employees. Some observers argue that the majority of worker burn-out is agency induced. For example, case-

loads are too high, work environments are poor, communication is lacking or management is disorganized. If that is indeed the case, the issue of burn-out may be addressed with one or more of the management approaches discussed earlier. For example, if workers lack incentive or motivation to maintain adequate performance, personnel practices could be revised to incorporate opportunities for upward mobility and rewards for exemplary performance.

Agencies have addressed the existence of burn-out in a more direct fashion. Following are some approaches.

1. The MINESOTA RESOURCE CENTER FOR SOCIAL WORK EDUCATION has developed a self-instruction manual for the Minnesota Department of Public Welfare. Behind Every Form There is a Person: A Handbook for Beginning Income Maintenance Workers provides an overview of the American welfare system, the administrative aspect of income maintenance programs, rights of the applicant/client, responsibilities and functions of the worker, and the development of interviewing skills. Minnesota's income maintenance programs are then discussed in detail.

   Contact
   Gordon Buyse
   (612) 296-2321

   An unusual feature of the Minnesota program is the tapes which accompany the handbook. These tapes complement the written material; together, these two media present a philosophy which serves to heighten worker sensitivity. For instance, the first tape provides general orientation which urges the worker to be sensitive to clients, reminds the worker of the client's right to assistance and their subsequent responsibilities, and speaks to the necessity of the worker's knowledge of self and how it interacts with the client. Subsequent tapes address the issues of the worker's unique opportunity to promote change of the laws and regulations, society's attitudes towards beneficiaries, and the importance of humanizing the system with respect and concern for clients. Other tapes supplement handbook materials for practical training, such as one which illustrates the spend-down policy by case example.

2. The OREGON PUBLIC WELFARE DIVISION'S STAFF DEVELOPMENT UNIT has produced a package entitled Working With the Hostile Client. A bright yellow pamphlet, addressed to the worker, begins by asking the question, "Why are welfare clients hostile?" The well-designed and illustrated booklet offers several excellent suggestions. A supervisor's training guide outlines a presentation designed for all staff who have client contact.

   Contact
   Rosa Smith
   (503) 378-5707

3. The CONTINUING EDUCATION BUREAU within the TEXAS DEPARTMENT OF HUMAN RESOURCES has developed a training guide entitled Eligibility Casework Skills. This guide is based on the premise that through using better human relations skills and by improving worker-client communication, workers will get more accurate and useful information from clients and deliver higher quality service. This in turn should reduce quality control errors. The training is also aimed at combatting problems such as caseworker burn-out, client complaints about workers and high caseworker turnover rates.

Contact
Loye Tankersly
(512) 835-0440

The major tool for use in implementing this training program is the Educational Director's Guide. This guide is divided into nine separate modules which should be delivered in sequential order. Burn-out, working with clients in stress, human relations skills, and working in a bureaucracy are but a few of the modules included in this package. A number of audio-visual aids are used in conjunction with the text.

Working Conditions: In 1975, Wayne County (Detroit) began a comprehensive study of its Department of Social Services. This initiative was prompted by frequent client and community dissatisfaction with delivery of services, low employee morale, disorganization and high error rates. These problems were exacerbated by a phenomenal growth rate in both clients and staff, highly centralized caseload management and inadequate facilities. This situation yielded poor service for clients, high employee turnover, inexperienced workers and supervisors, unnecessary absenteeism and tardiness, low productivity and lack of accountability.

The findings of this study generated the Wayne County Management Action plan. Five objectives were outlined:

1. Development of a decentralized organization with assigned accountability.

2. Acquisition of efficient facilities that are manageable, well located and well maintained, in which services can be humanely delivered.

3. Design of new systems and procedures which will contribute to more efficient operations, and higher morale on the part of workers.

4. Improvement of personnel policies to enhance qualifications and performance of personnel throughout the organization.

5. Implementation of management reporting, monitoring and evaluation systems.

The second objective with its attention to physical surroundings represents an unusual recognition of the importance of working conditions to employee performance, client satisfaction and efficient service delivery. Jack Dempsey, Director of the Michigan Department of Social Services, expresses this concept: If we expect caseworkers to function as professionals, clean and decent surroundings should be provided so that clients may be treated as human beings.

The development of new facilities involved the establishment of small districts, each served by a standardized modular office. Wayne County has developed a model district office and a model staffing plan. These new offices are located in areas of projected caseload growth so that clients can be most conveniently served. A standardized facility has been designed to optimize efficiency and environmental pleasure. The Herman Miller Research Corporation's report on The Department of Social Services Office Innovation Project concluded that work surroundings can significantly increase employee satisfaction and productivity. A successful facility should integrate the work process with the physical plant and be capable of growth and change. Facility management must be continually viewed as an integral part of agency management. (Tom Behnke - (313) 256-2711)

Needs Assessment Questionnaire: This questionnaire to caseworkers was developed by HCFA's Corrective Action Projects Division and the Illinois Department of Public Aid to assess the range of problems encountered in the field when determining Medicaid eligibility. Forms were developed to code and analyze the responses. The results can be used by a State to decide whether to publish a separate Medicaid manual, change the format of current manuals, establish training programs, or revise current policies. An agency using this Needs Assessment Questionnaire might wish to develop sample eligibility cases for pre-and-post-tests to be sent to a selected sample of caseworkers within the State to assess their knowledge of Medicaid policy and procedures and/or the effectiveness of new handbook materials.

Once received, responses to the questionnaire might be analyzed as follows:

1. How many caseworkers, who receive "on the job" training, felt that material in the policy section of the manual was effective and useful in answering a question relating to eligibility?

2. How many caseworkers, who currently collect information related to health insurance that an applicant/recipient may have, are aware that other payment sources should be exhausted before Medicaid?

3. How many caseworkers, who felt that the present manual does not help much in answering questions, would prefer a change in the amount of material in the manual?

4. Comparison of the average number of cases per worker in offices that have a separate Medicaid-only unit with number of cases per worker in offices that do not have a separate Medicaid-only unit.

5. Of the caseworkers who had developed their own techniques for making the manual more useful, how many felt that the amount of material contained in the manual should be expanded or reduced?

6. Comparison of the length of time since average MA-only caseworker has attended formal staff development training session with other caseworkers in the State.

Some minor changes have been made to the questionnaire so that the language is not specific only to Illinois. Other States may wish to use it to assess the needs of their caseworkers.

PLEASE RETURN QUESTIONNAIRE TO _____ BY _____

NAME OF OFFICE _____

CHARACTERISTICS OF CASEWORKERS AND WORKLOAD

1. How long have you been responsible for determining a client's eligibility?
   a. _____ Years
   b. _____ Months (if less than 1 year)
2. What is your educational level?
   a. _____ Less than high school diploma
   b. _____ High school graduate
   c. _____ Post-high school or some college courses
   d. _____ Earned Bachelor's degree
   e. _____ Some work on Master's degree
   f. _____ MSW/other Master's degree
3. How long since last highest educational level was attained?
   a. _____ Less than one year
   b. _____ 1-3 years
   c. _____ 4-7 years
   d. _____ More than 7 years
4. What is your age?
   a. _____ Years
5. The following title best describes my job responsibilities:
   a. _____ Intake eligibility worker
   b. _____ Income verification worker
   c. _____ Institutionalized Individuals worker
   d. _____ Medically Needy (MA-only) worker
   e. _____ Other (specify) _____
6. Is there a separate Medical Assistance (MA-only) Unit (or MA-only caseworkers) in your office?
   a. _____ Yes
   b. _____ No
7. My total caseload now is about _____(number) cases.
8. Approximately what percentage of your caseload is:
   a. _____ Aged, Blind, Disabled
   b. _____ AFDC
   c. _____ Food stamps only
   d. _____ Institutionalized Individuals
   e. _____ Medically Needy (MA-only)
   f. _____ Other (specify)_____

   100% - TOTAL
9. Do you process spend-down (or excess income) cases?
   a. _____ Yes
   b. _____ No
10. What is your classification? (Circle one)

    Caseworker I II III IV V VI VII

11. Do you have a backlog of cases pending:

Enter the approximate number you have pending for each program. Enter NA if you do not handle a caseload for the program

| | Application | Verification | Redetermination |
|---|---|---|---|
| Aged | | | |
| Blind | | | |
| Disabled | | | |
| AFDC | | | |
| Food Stamps | | | |
| Institution. | | | |
| MA-only | | | |
| Other | | | |

MANUAL FORMAT AND USE

12. How often do you find what you are looking for in the manual within a short period of time?
    a. _____ Always
    b. _____ Most of the time
    c. _____ Sometimes
    d. _____ Seldom
    e. _____ Never
13. When you have a question, how often is material in the policy section of your present manual effective and useful to you?
    a. _____ Always
    b. _____ Most of the time
    c. _____ Sometimes
    d. _____ Seldom
    e. _____ Never
14. The present manual usually:
    a. _____ Answers my questions and explains the policy.
    b. _____ Answers my question but does not explain the policy.
    c. _____ Provides general guidance but does not answer most questions.
    d. _____ Does not help much in answering my questions because:
       aa. _____ too hard to find things.
       bb. _____ wording is too vague
       cc. _____ wording is too complicated
       dd. _____ it's out-of-date
       ee. _____ it's not handy to my desk
       ff. _____ other

NAME OF OFFICE _____

15. Do you feel that the amount of material in the present manuals should be:

a. _____ Expanded to give more detail.

b. _____ Cut down to just the things I need most often.

c. _____ No change.

16. Are manuals readily available for your personal use:

a. _____ Yes

b. _____ No

17. What aids have you or your office developed to make your manuals more useful:

a. _____ An index list of where to find key sections.

b. _____ Index tabs (on the back of this paper, please list the subjects on tabs you have put on your manuals)

c. _____ "Ready reference" summaries of manual materials, such as checklists of steps to follow or forms to fill out.

d. _____ Removed or xeroxed manual pages I use most often.

e. _____ Other (specify)_____

18. Check any of the following changes you would like in the manuals.

a. _____ An up-to-date index

b. _____ A separate manual, section or color pages for sample forms and their instructions

c. _____ A glossary or dictionary of terms

d. _____ Dividers with pre-printed index tabs

e. _____ "Ready reference" guides or checklists to summarize some policies and procedures

f. _____ Different color-coding of manual pages, or more different colors to help identify different types of material.

g. _____ Smaller manual subject sections (such as "booklets") that each worker could select and put in a binder suited to his/her needs.

h. _____ Other (specify)_____

19. Would you like:

a. _____ a separate MA-only manual

b. _____ a separate MA-only chapter in each of the existing manuals

c. _____ dividers with preprinted index tabs just for MA-only manual subjects

d. _____ "ready reference" guides just for MA-only materials

e. _____ a separate index just for MA-only manual materials

POLICY DISSEMINATION AND TRAINING

20. When there are manual revisions, do you receive them within:

a. _____ days (How many)

b. _____ weeks (How many)

c. _____ months (How many)

21. Are the manuals you usually use kept up-to-date?

a. _____ Completely

b. _____ Mostly

c. _____ Partly

d. _____ Not at all

22. When you have a question about policy or procedures, how often do you consult your: (Check one in each column)

| | Manual | Supervisor | Coworker | |
|---|---|---|---|---|
| a. | _____ | _____ | _____ | Always |
| b. | _____ | _____ | _____ | Often |
| c. | _____ | _____ | _____ | Sometimes |
| d. | _____ | _____ | _____ | Seldom |
| e. | _____ | _____ | _____ | Never |

23. When a question cannot be answered within the office, how is it resolved?

a. ___ Consult with other county offices ___ phone _____ memo

b. ___ Consult with regional office ___ phone _____ memo

c. ___ Consult with State office ___ phone _____ memo

24. In which subjects would you like more training (if any):

a. ___ Treatment of income

b. ___ Treatment of resources

c. ___ Disregards or exclusions

d. ___ Defining a family unit

e. ___ Family responsibility

f. ___ Spend-down (excess income)

g. ___ Change of status cases (e.g., AFDC to MA- only)

h. ___ Institutionalized cases

i. ___ Other (specify)_____

25. Do you feel that you understand Medicaid eligibility policies and procedures well enough to carry out your responsibilities?

a. ___ Yes

b. ___ No

26. How long since you attended a formal staff development training session (not one conducted by your supervisor)?

a. ___ Years

b. ___ Months (if less than 1 year)

27. When there is a change in policy or procedures, do you usually:

a. ___ get formal training from outside your office, by ___ central office ___ regional office

b. ___ get formal training by your supervisor

c. ___ get informal guidance by your supervisor

d. ___ learn "on the job"

NAME OF OFFICE _____

OTHER HEALTH INSURANCE COVERAGE

28. Do you collect information about other health insurance coverage that the applicant or recipient may have?

a. ___ Yes

b. ___ No

29. If yes, is that information:

a. ___ filed but seldom used

b. ___ forwarded to another office. Name Office _____

c. ___ used to answer questions from doctors, hospitals, etc.

30. Are you aware that Medicaid is the last payor?

a. ___ Yes

b. ___ No

31. Would it be helpful to you if policies and procedures about other health insurance coverage were expanded in the manual?

a. ___ Yes

b. ___ No

Selected Training Materials

Interview Techniques: The term "interview" has been defined as "a conversation with a purpose, a purpose mutually accepted by the participants." For the Medicaid worker, interviewing will be used more than any other single tool in the successful accomplishment of their tasks. The Medicaid worker will interview to get information for the agency and to give information about the agency.

State agencies have developed many training materials that focus on interviewing techniques. A description of some of these materials follows:

1. An Aid for Teaching Interviewing in Eligibility Determination. This is a syllabus for case supervisors for use in teaching interviewing.

Contact

Albert Harrison
Family Security and Training Consultant Dept. of Health and Human Resources
P.O. Box 44065
Baton Rouge, LA. 70804
(504) 342-4110

2. Handbook on Eligibility Interviewing. The purpose of this handbook is to provide a summary of techniques and approaches that assistance payment supervisors may utilize in helping the assistance payment worker upgrade their skills and knowledge level in the area of eligibility interviewing, using the conventional method for eligibility determination as a model. The handbook contains a bibliography of materials relating to interviewing.

Contact

Same as #1 above

3. The School of Social Welfare, University at Albany, has developed a wealth of material for use in its Income Maintenance Medical Assistance Training Program. Included are:

Program for Workers -- The document can be viewed as a chronology and model of curriculum development and implementation. Others seeking to develop training programs might gain insight into the process through looking at the one described in the document. It details a field-tested program

Contact

Sally Berdan, Editor Continuing Education Project School of Social Welfare
(Draper) State Univ. of New York at Albany
135 Western Ave.
Albany, NY 12222
(518) 455-6245

which itself might be used in whole or in part for comparable target populations.

The major portion of the book is the fifteen individual modules of the worker training program. They appear in the actual order of presentation. The modules are not only segments of a focused training program but, as the structure makes clear, are specific training plans for individual topics and may be utilized accordingly.

| | |
|---|---|
| Enhancing Interviewing Skills of Medical Assistance Workers--A Training Manual. This manual is designed to provide staff development and training personnel with a practical guide for conducting interviewing skill instruction for MA workers. One element discussed is self-awareness or self-management skills. Another element discussed is the variety of such direct communication skills as questioning techniques and dealing with discrepant information. A video film series is available to accompany the manual. The manual has an extensive bibliography. | Contact<br>Same as #3 above |
| Interviewing for Medical Assistance Examiners--Self-Instructional Material. This instructional pamphlet is designed to meet the following objectives:<br><br>a. To identify for the worker the basic objectives, principles and techniques of interviewing;<br><br>b. To identify what a worker is to do in an eligibility determination interview;<br><br>c. To help develop the ability to obtain accurate and reliable information necessary for the determination of eligibility through the interview process; and<br><br>d. To enhance the worker's skills in communication in giving clients the facts about the various programs within the agency, the various types of medical services, and the client's rights and responsibilities as related to the Medical Assistance Program.<br><br>Price list for all of the above is available upon request to contact shown. | Contact<br>Same as #3 above |
| 4. Behind Every Form There's A Person: A Handbook for Beginning Income Maintenance Workers. The MINNESOTA RESOURCES FOR SOCIAL WORK EDUCATION has developed for the MINNESOTA DEPT. OF PUBLIC WELFARE this self-instructional manual. This handbook provides an overview of the American welfare system, the administrative aspect of income maintenance programs, | Contact<br>Gordon Buyse, Staff Development Consultant Dept. of Public Welfare 4th Floor Centennial Bldg. (612) 296-2321 |

rights of the applicant/client, responsibilities and function of the worker, and the development of interviewing skills. Audio tapes are included in the handbook. At present, handbook and tapes can be purchased for $15.00.

5. OREGON has developed a training package which includes:

Contact

Rosa Smith
Office Manager
Staff Development Unit, AFS Dept.
Human Res. Public Welfare Div. Public Service Bldg.
Salem, OR 97310
(503) 378-5707

Supervisor's Training Guide -- This was designed to be presented to all staff who have client contact. It is packaged with instruction to the trainer which will enable any manager, trainer or supervisor to deliver the training with very little preparation.

Pamphlet -- "Working with the Hostile Client." This pamphlet was produced by the Staff Development Unit in October 1976. It is addressed to the worker and begins by asking the question "Why are welfare clients hostile?" This booklet offers several excellent suggestions.

Contact

Same as #5 above

Audio-Visual Aids--Audio tapes on interviewing are available. On one tape, several food stamp supervisors discuss their experiences with different types of interviews. On another, six different interviews are presented; each interview is followed by a critique by a psychiatrist. Another tape is on hostility. There are also sixty-one slides on building relationships (with an emphasis on the skill of interviewing). Included are mock interviews between worker and client.

Contact

Same as #5 above

The training guide can be delivered by line supervisors during their unit meetings. There are six units (modules) and the course can be delivered in one six-hour session or six one-hour sessions. There is some variation in the material for clerical/receptionist staff and for assistance workers.

Because of numerous requests for this material, Oregon offers the Hostile Client package for sale. The price is $50.25 and reflects the cost of materials and handling charges.

6. SOUTH CAROLINA has developed Orientation Training for New Caseworkers--Module IV. This focuses on the essentials of the interviewing method. After completion of this training, trainee will be able to:

Contact

Director, Staff Development and Training South Carolina Dept. of Social Services
P.O. Box 1520
Columbia, S.Car.
(803) 758-3628

a. Explain the importance and purpose of interviewing;

b. Identify the four basic skills of interviewing;

c. Use or apply the four basic skills of interviewing;

d. Discuss factors in interviewing that affect information gathering;

e. Identify, discuss, and be able to apply the five basic principles of social work as they relate to interviewing; and

f. Role play an interview using all the basic skills of the module.

7. TEXAS has developed the Educational Director's Guide--Telephone Interviewing. This is a set of four modules designed to build upon the concepts in each of the preceding modules. The purpose of the modules is to provide staff with an awareness of the importance of proper telephone procedures and good telephone etiquette. Module one uses group discussion focusing on the purpose for training and the techniques useful to telephone interviewing. Module two consists of a simulation exercise using several role play situations. Module three focuses on the observer's role in module two, discussing the good and bad parts of the simulation. Module four deals with problem solving, utilizing the observer's comments from module three and soliciting input from the large group of participants.

Contact

Dr. L.G. Ferguson Chief, Texas State Dept. of Public Welfare
Continuing Education Bureau
Fountain Park Plaza I
300 South IH 35
Austin, TEX 78704
(512) 454-3781

8. The Office of Quality Assurance/Division of SSI Training developed a module on interviewing techniques in January 1978. This training package was designed to be used as instructional material in the course, Interviewing Techniques. The object of the course was to aquaint the quality assurance specialist with effective interviewing techniques used in QA interviews. Upon completion of the lesson, the QA specialist should be familiar

Contact

Office of QA
Div. of SSI
Quality Review Operations Branch
DHEW - SSA
Balto. Md.
21235

with the positive interviewing practices which result in an effective successful quality assurance case review.

| | | Contact |
|---|---|---|
| 9. | Interviewing in Social Security--As Practiced in the Administration of Retirement, Survivors, Disability Health Insurance, and Supplemental Security Income -- This booklet was written for the beginning interviewer in old-age, survivors, and disability insurance. It was designed for use in in-service training as an orientation to the philosophy and the interviewing objectives and methods of this part of the program of social security. The booklet includes case illustrations and records of interviews. These interviews show mistakes as well as illustrate good practices; their analyses of interviewing strengths as well as weaknesses have provided the base and substance of the book. | Div. of Technical Training<br>Social Security Administration<br>DHEW 4 N-8 Annex<br>Balto., Md. 21235<br>(301) 594-2906 |

Conclusion

This section has presented various approaches which States use to increase caseworker efficiency. It can serve as a resource guide that States can use in their efforts to increase the effectiveness of Medicaid eligibility caseworkers.

CAP welcomes any additional information on this subject. States may send any material they believe would be valuable to others (training programs, performance standards, work management, working conditions, needs assessment tools, interviewing techniques, etc.) to:

Thelma H. Johnson, Program Analyst
Corrective Action Projects Division
Medicaid/Medicare Management Institute
Dept. Health, Education, and Welfare
Mail Drop 389 - East High Rise (3rd Floor)
6401 Security Blvd.
Baltimore, Maryland 21235

# APPENDIX

ALASKA

The Medicaid Program Learning Package
Authorizing Payments for AFDC Households

ARKANSAS

Training Resources on Interviewing
The Complete IM Worker: An Orientation Packet for New Employees

CALIFORNIA

Medi-Cal Eligibility Manual-2
Medi-Cal Content Outline
> Los Angeles County
Assessment Test
Eligibility Determination Training Module/AFDC/Boarding Homes and Institutions
Unemployment Insurance and Disability Insurance Benefit Training Manual for AFDC
Veterans' Benefits Verification and Referral System Training Module
Earnings Clearance System Training Module
Training Package - San Francisco

DELAWARE

Accepting Challenge and Change: Assistance Payments Supervision
Management Tools for AP Supervision
AP Supervisory Course - Promotion

FLORIDA

Public Assistance Supervisors Training Handbook

GEORGIA

Things to Look for in Completing Medicaid Claims
Fiscal Year 1979 Training Plan - Divison of Family and Children Services

ILLINOIS

AFDC Caseworker II Training Packet
Supervisory Work Shop

INDIANA

Communication
Community Resources
Supervision Is
Caseload Management
General Principles of Interviewing

KANSAS

PA/MA Training Kit

KENTUCKY

Orientation Training

LOUISIANA

Handbook on the Eligibility Interview

MASSACHUSETTS

Medical Assistance Training Package: Mass. Department of Public Welfare

MINNESOTA

Behind Every Form There's a Person: A Handbook for Beginning Income Maintenance Workers

MISSISSIPPI

A Supervisory Guide to Training Eligibility Workers
This is Where You Start (for Eligibility Workers)

MONTANA

Quarterly Training Schedule - July-September 1978

County Based Eligibility Technician Orientation

NEVADA

Medical Manual

NEW JERSEY

Orientation Program for New Personnel

NEW YORK

Task Analysis in Public Welfare Staff Development: A Report on the New York City Experience
Enhancing Interviewing Skills of MA Workers: A Training Manual and a Regulations and Procedures Supplement for Trainers
An Evaluation Plan and Instruments for IM and MA Training
Training Resources for Supervisors in IM and MA
Interviewing for Medical Assistance Examiners
List of Training Resources
Desk Reference Guide for Medicaid Eligibility
Training Resources for Workers in IM and MA
Program for Workers - IM/MA Training

OKLAHOMA

Physician's Manual
Hospital Manual
Special Medical Services Unit Procedure Manual
Medical Assistance Manual
Physician Auditor's Manual
Medical Units' Procedure Manual
Supervisor's Guide for Orientation of Workers in Division of Assistance Payments

ONTARIO, CANADA

Competency-Based Analysis of the Field Worker

OREGON

Training Agenda
Core Curriculum Cards
Core Curriculum Packets
Hostile Client Packet
Merit System (Oregon System)
Instructor Training Workshop

PENNSYLVANIA

Income Maintenance Training Program/AFDC: "How They Do It"
Income Maintenance Standard Training Program

SOUTH CAROLINA

Medical Assistance Division Training Agenda

SOUTH DAKOTA

Training Needs Assessment Questionnaire for Medical Services Caseworkers

TEXAS

Educational Director's Guide: Telephone Interviewing
Educational Director's Guide: Medicaid Eligibility Orientation
Fraud Recoupment and Overissuance

VERMONT

Becoming a Helpful Supervisor: Training Outline

WISCONSIN

The Wisconsin Interactive Teaching System/AFDC

# THIRD PARTY LIABILITY DEVELOPMENT IN STATE AND LOCAL AGENCIES

by Martha Green

## Introduction

In administering the Medicaid program, States have a dual responsibility. One of these, as written in 42 CFR 206.10 (a)(3) is to the client. It states that all applicants must receive a prompt decision on their application for benefits, and if found eligible, must receive those benefits to which they are entitled in a timely manner. Equally important, although less clearly stated, is the State's responsibility to the taxpayer, to ensure that both Federal and State funds are expended for benefits in the correct amount, in accordance with the individual's resources and income. These benefits include medical services received by the beneficiary through the Medicaid program, as well as direct cash assistance received under other Titles of the Social Security Act.

Before cash assistance is granted to an individual, the applicant's income and resources are identified, pertinent facts are developed, and documentation is made part of the case file according to each State's requirements. Before medical service benefits are granted, any income or resources which may affect the entitlement or scope of benefits to be made available to the beneficiary should be developed and documented in the same way. Although third party medical resources in the form of health insurance, casualty or tort-related awards, or probate collections are not resources which affect the cash payment to the beneficiary, they are critical resources to be considered in determining the payment made to medical providers on the beneficiary's behalf, since Medicaid is the "payor of last resort." Historically, however, the identification of third party insurance and other medical resources (MR) has been underdeveloped, or ignored. Third party liability (TPL) errors are estimated to generate a financial loss of approximately four percent of the total vendor payments made under Title XIX. Based on estimated Medicaid expenditures for FY 79, this is approximately $786,480,000.

## Point of TPL Development

Since Medicaid eligibility is not always determined by the single State agency responsible for administering the medical assistance program, appropriate TPL development may require coordination among several State agencies. Ideally, potential medical resources should be documented at the point of intake by the local office as part of the application process, concurrently with other resources which may affect the scope of benefits to which the applicant may be entitled.

Although this development can be undertaken by a unit other than the local agency, or after the eligibility determination has been made by the local office, this has several disadvantages. Medical resources development by a separate agency necessarily involves a time loss between the point of referral of the case by the local office and recontact with the client. During this time Medicaid eligibility may be suspended; or if granted, medical bills may be processed and paid by the State without appropriate TPL information.

The local office intake interviewer, on the other hand, can collect medical resource information as part of the application interview, and thus eliminate the necessity of a potentially confusing and inefficient recontact with the client. The interviewer has the advantage of a face-to-face contact with the claimant, and can assist the claimant in understanding the "last payor" concept and reporting responsibilities for TPL-related changes as well as other changes affecting benefits. The worker can also correlate other income and resource information, including pending legal actions or claims for other benefits, which may indicate a current or future medical resource available from a third party.

Not all Medicaid eligibility determinations are made by State or local public assistance agencies, however. In States which have signed Section 1634 agreements with the Secretary of the Department Health, Education, and Welfare, the Social Security Administration (SSA) makes the Medicaid eligibility determination concurrently with the Supplemental Security Income (SSI) determination. But SSA does not undertake comprehensive TPL development; the SSI claimant is asked only whether other medical resources exist. Additionally, this information is not always transmitted to the Supplemental Security record and therefore, is not always available on the State Data Exchange (SDX). Hence, States signing Section 1634 agreements must designate an agency to collect the necessary TPL information from the SSI population upon notification of the Medicaid eligibility determination.

TPL Development Procedures

Each State differs in the manner in which it administers its public assistance programs and these differences will influence some of the procedures which are developed to investigate potential medical resources. Whether development of the required data occurs during or subsequent to intake, by the caseworker or by a separate agency, the vehicle to capture the information will either be the application or a separate form:

- The application itself can contain detailed questions covering all the data elements required, as in the Wisconsin application.

- The caseworker or separate agency can record information during the interview on a separate form. This may be preferrable for States having limited systems capabilities for storage, or "1634 States" compelled to use two methods to collect MR/TPL information but wishing to develop procedural consistency for the entire Medicaid population at the earliest point.

- A separate form may be given to the client by the caseworker or mailed by a separate agency, with the explanation that it is the client's responsibility to complete and return the form to the appropriate agency. This method is not expected to produce efficient results unless the State requires the return of the competed form as a condition of eligibility and prevents the issuance of Medicaid card until the information is received. This procedure is currently in place in Minnesota.

Regardless of the agency made responsible for TPL development, or of the forms process used, the TPL information needed by the claims payment function to ensure appropriate payments by liable third parties remains constant and specific. No sophisticated training is required for caseworkers to extract this information, beyond a general knowledge of routine private insurance provisions, benefits available from other Federally and State administered benefit programs, and the concept of legal liablility in casualty or tort situations.

The data required for third party identification and benefit recovery depends on the type of medical resource which is available to the client:

All Cases:

1) recipient name
2) date of birth
3) sex
4) social security number
5) case identification number
6) assignment of benefits statement (if the State has no subrogation law)

Federally and State Administered Benefit Programs:

1) program name
2) recipient class of coverage (i.e., Part A and B)
3) program I.D. number

Private Health Insurance:

1) type of insurance
2) date of coverage
3) insured party name
4) relationship to insured
5) name of carrier
6) address of carrier
7) group names
8) group or certificate number
9) contract policy number
10) I.D. of covered individual in the case

Health Maintenance Organization:

1) name and address of the HMO
2) membership or contract I.D. number
3) date of enrollment

Potential Tort or Casualty Benefits:

1) narrative description of accident or potential tort benefits, to include attorney name, if available.

Although the claimant will usually be able to give all the information necessary to document available medical resources, there are three other methods to identify potential medical coverage: case record review, data exchange, and claims processing edits.

Case Record Review: The case record contains information which may strongly indicate the presence of a medical resource:

1) Age - If the applicant is over age 65, they are either already entitled to Medicare Part A and B, or it may be purchased.(See Buy-In). If the claimant is a student under age 18, or over 18 in college, there is a strong possibility of insurance made available through the school.

2) Death - In applications for persons now deceased but eligible in the retroactive period, there may be "last illness" coverage available through many life insurance policies, or in accordance with 42 CFR 433.36 (f) probate collections may be required from the estate in certain cases.

3) Income - Certain income sources, if specified, will be indicators of possible third party health coverage:

   a) Railroad Retirement Benefits and Social Security Retirement/ Disability Benefits indicate eligibility for Medicare benefits under Title XVIII.

   b) Longshore and Harbor Worker's Compensation (LHWC) and Workman's Compensation (WC) are both administered by the Department of Labor. Under both programs, employees who suffer injury or accident consequent to conditions arising from employment may file for benefits to compensate for medical expenses as well as lost income. Payments for medical expenses may be made either as medical bills are incurred, or as a lump sum award.

   c) "Black Lung Benefits", payable under the Coal Mine Workers Compensation Program, also administered by the Department of Labor, are similar to those described above except that benefits are only awarded on a diagnosis of pneumonosiliconiosis due to work as a coal miner. Only specific providers authorized by the Department of Labor may render services in order for the beneficiary to be reimbursed. "Black Lung" payments are made monthly and medical expenses are paid as incurred.

   d) Title IV-D Payments or financial support payments from an absent parent, strongly indicate potential medical support as well. An absent parent may be required by court order to provide medical insurance premium payments in addition to support payments; they may be required to undertake a portion of medical bills which may be incurred, or, if employed, may be

required by court order to include dependent children in the medical insurance made available by the employer. New Federal regulations require the Title IV-D agency to develop medical support in addition to monthly child support payments for certain cases. (42 CFR 448 and 450; 45 CFR 301, 302, 304, 306.)

e) Earned income usually indicates medical and health insurance made available by an employer.

If a separate agency is responsible for TPL development, the information in 1) through 3) would only be available if the State had a relatively sophisticated automated eligibility file. Even then, the elapsed time between client application and establishment of the case record on the automated file may prove too long for maximum efficiency.

More data, from which to develop potential third party medical coverage but of a type not routinely transmitted to systems, exists in the case record. This information therefore, would usually only be available to the caseworker or other local agency personnel:

4) Work history - An applicant's work history may reveal possible pension benefits but also related health benefits. For instance, some claimants may not realize that they may be insured for Social Security Retirement payments Medicare based on long-forgotten work or "deemed" work credits received through military service, or both.

5) Disability history - Information concerning the nature of the disability may lead to third party medical resources which had been overlooked. In the case of traumatic injury, there is potential for tort or casualty claims: Worker's Compensation for job-related injury, or legal action for insurance benefits for injuries sustained in an automobile accident. Also, certain chronic illnesses may suggest eligibility for medical benefits from another assistance or insurance program: chronic renal disease cases are highly likely to have Medicare coverage, and as previously mentioned, pneumonosiliconiosis may imply eligibility for "Black Lung" payments. Finally, persons receiving Social Security disability payments are eligible for Medicare in the 25th month after the beginning of the disability period.

6) Monthly expense information - The client budget may show monthly/quarterly or yearly insurance payments for private medical insurance.

The agency responsible for investigating current MR/TPL sources must also have a procedure to monitor those cases which may have medical resources either upon adjudication of a pending claim for benefits with another organization (SSA, "Black Lung", Workman's Compensation, Longshoreman's Benefits); which may be pending final litigation in casualty or tort cases; or which may involve collections through probate.

Cases eligible for buy-in (either for Medicare, or at State option, any other health insurance) at the time of application should be immediately processed as buy-in enrollments. Those not yet eligible for Medicare should have the DOME (Date of Medicare Entitlement) identified either from the buy-in reject notification or computed from the Beneficiary Data Exchange (BENDEX) by calculating age or length of disability entitlement, and should be carefully monitored to ensure that Part B enrollment is established at the earliest possible date.

Data Exchange: The second major technique which may be used to identify potential third party coverage is data exchange. Data matches can both corroborate and supplement the evidence in the case record. Some exchanges are primarily useful in updating income and resource data which, as discussed earlier, may indicate other medical resources; other data exchanges such as those with major health insurors, may result in the direct identification of health coverage.

Among the more successful automated and manual data matches being performed in many States are the following:

1) State Data Exchange (SDX) - Provides information concerning the SSI population. The SDX printout provides data on the individual's resources, earned and unearned income, address, payment status, payee, and essential person information. The SDX also includes information concerning third party disability coverage (data element 420) and retroactive medical expenses (data element 421).

2) Beneficiary Data Exchange (BENDEX) - Provides information concerning awards made under Titles II (Retirement, Survivors, and Disability Insurance) and Title XVIII (Medicare) as well as Railroad Retirement Benefits (RRB) and "Black Lung" Benefits. The BENDEX is also useful in accomplishing the buy-in. New data elements are being included to further facilitate the accretion process.

3) Exchanges with State income tax agencies, large private employers, or local/Federal employers - Matching files with State income tax records or large local employers provides the opportunity to uncover not only unreported earned income, but also the health insurance coverage made available to employees. Michigan, for example, has undertaken such data exchanges with the major automobile manufacturers.

4) Exchange with major health insurance agencies - Some States have matched the eligibility files with the register of private insureds of large private health insurers. The largest problem in this type of match is in making positive identification of matches. Without a unique identifier, such as the Social Security number, the match may be impractical.

5) Divisions of motor vehicles - A yearly match against lists of persons involved in motor accidents may uncover other persons who may be legally liable for costs of medical care for injuries resulting from such accidents.

6) Claims processing edits - Along with case record review and data exchanges, the State can build in claims process screens to edit out invoices which have, or should have, third party liability indicators.

Claims processing (CP) edits may be designed to partially duplicate the analytical techniques used in case record review and data exchange to identify a potential third party resource which may have been overlooked at the time of intake. For example, the claims processing system could recognize that a recipient over 65, or one receiving absent parent support, should in most cases have a third party medical resource to be developed by the local agency. Complete TPL information, once collected, is best utilized when it may be input to the claims processing system to form a TPL data base against which claim invoices may be screened for possible third party involvement.

In addition, information available on the invoice itself may generate TPL information: diagnoses codes may suggest traumatic injuries arising from casualty or potential tort cases, or the provider may obtain information from the recipient which was not reported to the caseworker. Claims processing edits, however, cannot be relied upon to replace caseworker TPL development, and should be used as a cross check of the information collected at intake.

Transmission and Storage of TPL Data

Each State will have individual constraints concerning how the data, once collected, can best be stored for access by the claims payment function or the unit responsible for making third party benefit recoveries or both. States having relatively small Medicaid populations or sufficient program staff can consider less automated alternatives than States with the larger Medicaid populations or more serious staffing shortages. Ideally, all TPL information should be input by the local office to an automated eligibility file which forms part of the data base for the claims payment system. In Ohio, TPL information is input to a separate TPL data base which is accessed by the claims payment system.

Minimally, the claims payment function should be provided with an indicator to show whether any particular beneficiary has any other medical resource, so that provider invoices for services rendered to that individual would be referred to the TPL unit for appropriate action, as is the case in Minnesota. In this situation, the detailed information on the third party resource is contained either in the case record in the local agency, or if collected on a separate form, may be centrally filed with the TPL unit.

In addition, TPL indicators can be printed on the Medicaid card itself, so that providers would be aware of the existence of other potential payors.

Ongoing TPL-Related Activities in the Local Offices

Past the initial development of TPL or MR, the local office will continue to be involved in TPL-related activities. Local agencies may become involved in investigating new or previously undeveloped TPL after

the point of intake at the request of another agency involved in claims processing when information is received which conflicts with information already on file. For instance, an invoice might show treatment for traumatic injury; the claims payment function might request that the local agency contact the client to obtain details.

In addition, TPL information should be reverified at the time of redetermination, as is other resource information. Changes in client income or circumstances should be reviewed not only in light of the potential effect on continuing eligibility, but also any implication the change might have in the area of other medical resources. For instance, although a return to full-time employment may terminate cash assistance for a client, medical assistance may continue for a short time. Health coverage available through the employer should be documented in order to correctly pay future Medicaid invoices.

State Support of Local Agency TPL Activities

States and counties adminstering the Medicaid programs may protect their administrative and fiscal interests in the area of third party liability recoveries by offering strong support to the local agencies in three significant ways:

1) Automated Eligibility Files - As the number, complexity, and frequency of Medicaid eligibility determinations and recertifications continue to increase, more and more States are designing automated systems to reduce the manual workload. As these systems are put in place, and as current systems are expanded, consideration should be given to the tremendous error reduction and cost savings potential available through third party recoveries if medical resource data is incorporated to the data base and made available to the claims payment function.

2) Training/Manuals - Training for both new and experienced caseworkers should incorporate a discussion of the importance of third party/medical resource development in Title XIX. The training syllabus should include capsule summaries of the eligibility criteria for health benefits as well as cash benefits available through other Federal and State programs, and should also attempt to teach the caseworker the techniques of correlating case information to extract medical resource indicators.

3) Local agencies need clear, up-to-date, written policies and procedural instructions in order to administer the Medicaid program efficiently; TPL should be incorporated as a distinct unit, covering the same factors given in the training.

4) Public Information - Since the claimant is the best resource for reporting changes in circumstances to the State agency, efforts should be made by the State to ensure that the beneficiary understands not only what must be reported, but how it affects the scope of entitlement to benefits under Title XIX. The caseworker should be encouraged to explain, to the extent possible, how the information collected at intake synthesizes to produce the eligibility determination. Pamphlets and brochures outlining the same information should be available for the claimant's home reference and use.

Efforts should also be taken to ensure that providers understand the "last payor" concept in Medicaid, and the importance of complete TPL information in maximizing both the amount and the speed of provider reimbursement from the appropriate payors.

In addition, the State should seek the support of large health insuring agencies within the State. In many States, contacts with the State insurance commissioner have been quite successful in opening communication channels with the health insurance industry.

For any program as complex as Medicaid to be successfully administered, the State must have current and correct information on all factors affecting entitlement and scope of benefits for each claimant. With strong State support for local agencies' TPL investigation as well as other related TPL data collection techniques, erroneous Medicaid payments can be substantially reduced.

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# Avoiding Erroneous Payments in State Medicaid Programs

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